PATIENT DEMOGRAPHICS
(PLEASE PRINT)

NAME: _____
First MI Last

DOB: _____ Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (___) _____ Work Phone: (___) _____

Cell Phone: (___) _____ E-Mail Address: _____

Gender: Male Female Social Security Number: _____

Height: _____ Weight: _____ Shoe Size: _____

Marital Status: _____ Occupation: _____

Employer: _____

Emergency Contact

Spouse/ Guardian/ Parent (circle one) _____

Employer: _____ Work#: (___) _____

Referred by: _____

Primary Care Physician: _____

Physicians Address/ Phone Number: _____

ASSIGNMENT OF BENEFITS AND RELEASE OR INFORMATION

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO SHELDON FLEISHMAN D.P.M., P.A.. I AUTHORIZE RELEASE OF ANY AND ALL INFORMATION REQUIRED BY THE INSURANCE COMPAY FOR PAYMENT OF BENEFITS.

_____
PATIENT'S SIGNATURE DATE

FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL SERVICES PERFORMED BY DR SHELDON FLEISHMAN D.P.M., P.A. AS WELL AS ANY COLLECTION FEES, COURT COSTS OR INTEREST THAT MAY BE ADDED TO MY BALANCE IF NOT PAID IN A TIMELY FASHION.

_____
PATIENT'S SIGNATURE DATE

PATIENT MEDICAL HISTORY INFORMATION

(CONFIDENTIAL INFORMATION IMPORTANT FOR OUR FILES AND YOUR HEALTH)

1) STATE IN YOUR OWN WORDS YOUR MEDICAL REASONS FOR COMING TO OUR OFFICE:

_____

_____

2) HAVE YOU HAD ANY UNUSUAL CHILDHOOD DISEASES SUCH AS POLIO OR SCARLET FEVER?

_____

3) PLEASE INDICATE "YES" OR "NO" IF YOU HAVE HAD SIGNIFICANT PROBLEMS IN THESE AREAS:

DIABETES_____ RECENT WEIGHT LOSS_____ THYROID_____HEADACHES _____ CHEST PAIN _____
TROUBLE WITH VISION _____ TROUBLE WITH HEARING_____ HIGH BLOOD PRESSURE _____
CIRCULATION_____HEART _____ SHORTNESS OF BREATH _____ TB OR PNEUMONIA _____ASTHMA _____
ALLERGIES/HAYFEVER _____ RESPIRATORY _____ LIVER DISEASE _____ GALLBLADDER DISEASE _____
STOMACH TROUBLE _____ ANEMIA _____ ABNORMAL BLEEDING _____ SKIN _____
ARTHRITIS/GOUT _____ SWELLING OF THE FEET/ANKLES/LEGS _____

4) LIST ALL MEDICATIONS YOU USE: _____

_____

_____

5) LIST ALL THE OPERATIONS THAT YOU HAVE HAD AND THE YEAR PERFORMED: _____

_____

_____

6) PLEASE LIST ANY ALLERGIES TO MEDICATIONS: _____

_____

7) DO YOU HAVE A PROBLEM TAKING ASPIRIN? _____

8) DO YOU SMOKE?(CIRCLE) YES NO HOW MANY PACKS PER DAY _____

9) PLEASE INDICATE WHICH OF YOUR RELATIVES HAVE HAD ANY OF THE FOLLOWING DISEASES:

DIABETES _____ CANCER _____STROKES _____
KIDNEY DISEASE _____ARTHRITIS _____GOUT _____
HEART TROUBLE/HIGH BLOOD PRESSURE _____ MENTAL DISEASE _____

10) ARE YOU PREGNANT _____ IF YES, HOW MANY MONTHS _____

PATIENT SIGNATURE _____ **DATE** _____

Sheldon Fleishman D.P.M., P.A.
1050 South Outer Road #100
Blue Springs, MO 64015

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize ***** to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient name:_____ **Date of birth:**_____
Persons/organizations to receive the information: _____

The specific information to be released/disclosed is specified below:

☐ **Complete Medical Record**
Or specify one or more of the following:

☐ Operative Reports	☐ X-rays
☐ Progress Notes	☐ Billing and Claim Records
☐ Laboratory	☐ (Other – specify) _____

This information is to be used/disclosed for the following purposes(s) only: _____

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on _____ (state date or event).

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

☐ **Yes** ☐ **No** _____ **Initials**

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):_____
Relationship to the patient (if applicable):_____

*** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT**

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____
(please print)

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by ***** and/or his staff be handled in the following manner:

- For written communications: Address to: _____
  _____
  _____
  _____
- For oral communications: Call: _____
  (telephone number)
  May we leave a message?
  Yes ☐ No ☐

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

_____
_____
_____

_____
Patient Signature

_____
Date

For Practice Use Only

Practice: ☐ Accepts ☐ Denies	
Privacy Officer Signature:	_____
Date:	_____

RESTRICTION REQUEST FORM

For Use and Disclosure of Patient Health Information

In completing this form, you are requesting that the following restrictions be considered as limitations to the use and disclosure of your protected health information.

Requested Restrictions (please provide specific details and dates):

_____

_____

_____

Print Patient Name: _____

Signature of Patient or Authorized Representative: _____

Date: _____

Relationship to Patient: _____

For Practice Use Only:

Practice: ☐ Accepts ☐ Denies

Privacy Officer Signature: _____

Date: _____

Note: The Practice must honor requests for restrictions of health information by the patient if (1) the disclosure will be to an insurance company for purposes of payment or health care operations, and (2) the patient has paid for the service out of pocket in full.

OFFICE FINANCIAL NOTICE

AS OF JANUARY 1, 2010 THIS OFFICE REQUIRES YOU LEAVE A MASTERCARD OR VISA ON FILE.

INSURANCE IS **NEVER** A GUARANTEE OF PAYMENT FOR SERVICES RENDERED.

IF YOU ARE UNABLE TO LEAVE A CREDIT CARD ON FILE, YOU WILL BE EXPECTED TO PAY FOR ALL SERVICES RENDERED ON THE DATE OF SERVICE.

SHELDON FLEISHMAN D.P.M., P.A.

1050 NW South Outer Road
Blue Springs, MO 64015
816-228-9393

10701 Nall Ave
Overland Park, KS 66211
913-381-5515

AUTHORIZATION FOR TREATMENT AND SERVICES, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND CHARGE TO MY CREDIT CARD

I hereby authorize and accept medical treatment for myself and for my dependents as deemed necessary by Sheldon Fleishman D.P.M., P.A. I also authorize Sheldon Fleishman and his officers, directors and his designated employees and agents to furnish information to insurance companies and other medical professionals regarding treatment and services provided to me and for my dependents, and regarding my medical condition and those of my dependents. I hereby assign to Sheldon Fleishman D.P.M., P.A. and to his employees all payments made for medical treatments and services provided to me or to my dependents. I understand and agree that I am primarily responsible for the payment of all charges rendered by Sheldon Fleishman D.P.M., P.A. I understand and agree for such medical treatments and services whether or not such charges are covered (either fully or partially) and paid (either fully or partially) by insurance.

I fully understand the policy of Sheldon Fleishman D.P.M., P.A., which is secure an imprint of my credit card at the time of my initial office visit. If, after a claim has been submitted to my insurance carrier(s), either the claim is denied for any reason or the charges are either not paid or only partially paid, by my insurance carrier(s), then in any of such events, Sheldon Fleishman D.P.M., P.A. will charge my credit card for the amount then owing for medical treatment and service provided to me, and my insurance carrier subsequently makes payment to Sheldon Fleishman D.P.M., P.A. of all or a part of such charges, that Sheldon Fleishman D.P.M., P.A. will issue a credit in such amount received from my insurance carrier to my credit card.

Credit Card Type ___Visa ___MasterCard
Credit Card Number: _____
Expiration Date: _____
Name of Card Holder: _____
Name of Patient: _____
Address: _____
_____
Telephone Number: _____

I hereby authorize and direct Sheldon Fleishman D.P.M., P.A. and his designated agents and employees to process and charge my credit card the full amount of all charges made for medical treatments and services provided by Sheldon Fleishman D.P.M., P.A. I understand that the amount charges to my credit card will be reflected on my credit card statement. The amount charged will be based on the medical treatment and service rendered to me or my dependents as requested by me and the usual and customary charges made by Sheldon Fleishman D.P.M., P.A.

Notwithstanding the above, I hereby guarantee payment of all charges for medical treatments and services provided to me or to my dependents by Sheldon Fleishman D.P.M., P.A. and agree that if Sheldon Fleishman D.P.M., P.A. places my account in the hands of a collection agency or an attorney for enforcement or collection in either such event, Sheldon Fleishman D.P.M., P.A. shall have the right to be paid back by me for all of his costs and expenses in collecting monies owed to them by me for medical treatment and service provided to me to the extent not prohibited by applicable law. Those expenses include, for example, but shall not be limited to, reasonable attorneys' fees, court costs and other expenses incurred in connection with collection of my account by a collection agency or an attorney.

This authorization shall be and remain effective unless and until expressly revoked by me in writing delivered to the office of Sheldon Fleishman D.P.M., P.A.

_____ _____
Signature of Patient/Responsible Party Date

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

*****

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect <insert date>, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Sale of Health Information: We will not sell or exchange your health information for any type of financial remuneration without your written authorization.

Fundraising Communications: We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Fundraising Communications: We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. If we are paid by a third party to make marketing communications to you about their products or services, we will not make such communications to you without your written authorization. Except as stated above, no other marketing communications will be sent to you without your authorization.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make

repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you **25¢** for each page, **$15.00** per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January 1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your

request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Tiffany Nicole
(P) 816-228-9393 (F) 816-228-5462
1050 South Outer Road #100
Blue Springs, MO 64015